MONTANA STATE BOARD OF NURSING
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OFFICE USE
PROG#_____
APPROVED:
YES__ NO__
DATE_____

ASSISTED LIVING MEDICATION AIDE PROGRAM APPROVAL APPLICATION

Attach a complete program outline or syllabus along with a schedule of clinical hours and the name of the facility where the clinical hours will be met.

CONTACT PERSON:_____ Telephone:_____

ADDRESS:_____
(STREET, PO BOX) (CITY) (STATE) (ZIP)

PROGRAM TITLE:_____

PROGRAM INSTRUCTOR(S)(must be approved by the Board of Nursing):

_____

_____

I hereby certify the above titled program includes the following, which meets or exceeds the provisions of 8.32.427:

Total hours of instruction time

Total hours of didactic classroom presentation: _____ (32 hrs minimum)

Total hours of simulated practical experience: _____ (8 hrs minimum)

Total hours of direct, supervised, clinical experience _____ (40 hrs minimum)

Instructor to student ratio

Classroom setting:_____to_____
Minimum ratio = 1:10

Clinical setting:_____to_____
Minimum ratio = 1:10

The following mandatory Components are included:

___ The six rights of medication administration
___ Purposes of medications
___ Classes of medications
___ Allowable routes of administration of medications
___ Care, storage and regulation of controlled substances and medications
___ How to administer medications
___ Adverse reactions, side effects and allergies to medications
___ Medication log
___ Medication error reporting
___ Documentation
___ How and when to report to the supervising nurse
___ Completion of the Board approved skills checklist

Signature:_____ Date:_____